We agree with Drs Fowkes and Fulton that most submitted articles are neither exceptionally good nor exceptionally poor as different aspects of a paper may vary in quality. As both authors and referees we have found rating scales on specific aspects of a paper (for example, theoretical contribution, methodological accuracy, recommendation for publication in the journal) together with free comments helpful and informative. As referees we have found the circulation of completed rating scales and comments among reviewers after the editorial decision informative and polite. If revision of the manuscript is recommended it is pleasing to be notified of the final outcome. This simple way of providing feedback to referees makes an often difficult and time consuming task worth while, increases motivation, and encourages conscientious appraisal. Publishing the names of reviewers in the journal is also a way of acknowledging their efforts.

Others may be able to contribute further suggestions that provide an incentive for referees and a fair and instructive appraisal procedure for authors.

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**We are well aware of the evidence that double blind reviewing of papers may result in a better outcome, but our judgment—and that of most other editors—is that the evidence is not yet solid enough to justify changing to such a system. The results of further studies will be published soon. We do feedback our final decisions to reviewers, but it might well be that we should feedback more information about how we reached our decisions. Finally, we pay our reviewers, but we are exploring further ways of rewarding them for what is a difficult, time consuming, and vitally important task.—ED, *BMJ*.

## Benzodiazepines and tinnitus

SIR,—In his discussion of the causes and management of tinnitus Mr M Hawthorne points out that benzodiazepines should not be used to treat tinnitus because their long term use is detrimental.[1] I should like to add to this that withdrawal of benzodiazepines after long term use is a well documented but often unrecognised cause of tinnitus.[2-5] It may be related to the hyperacusis characteristic of benzodiazepine withdrawal, and it usually disappears once withdrawal is complete—but I have seen patients in whom tinnitus persisted for many months after withdrawal from benzodiazepines was complete, and similar cases have been reported.[4] In one of the reported cases the tinnitus was relieved by diazepam.

Tinnitus is common and has many causes, but questioning patients about their use of benzodiazepines may elicit a cause that usually has a good prognosis.

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## Microvascular vasodilatation in non-insulin dependent diabetes

SIR,—Dr D D Sandeman and colleagues' paper on microvascular dilatation in diabetic patients raises some important points.[1] We agree that an impairment of the hyperaemic response to injury may be important in the pathogenesis of foot ulceration. It is interesting that they found such an impairment in the feet of people with newly diagnosed non-insulin dependent diabetes. We are surprised, however, they did not find such an impairment in the group of patients with insulin dependent diabetes matched for age and sex, especially when they quote a previous study that showed such an impairment.[2] This may be due to type II error resulting from the small numbers in the groups.

There seems to be a trend for lower hyperaemic responses in this group of patients than in normal controls (median in normal controls=1·65, median in insulin dependent diabetic patients=1·45). Another explanation may lie in the selection of patients as patients with type I diabetes with complications (such as retinopathy and neuropathy) have impairment of the reactive hyperaemic response to injury while those without complications have not.[3] We presume that none of the patients had a history of foot ulceration, and we are not told the extent of neuropathy in the two groups of diabetic patients, so the patients with insulin dependent diabetes selected (median duration of diabetes of 19 years) may represent a group of diabetic patients who do not have neuropathy and have been spared microvascular and macrovascular complications. The same cannot be said of the patients with newly diagnosed non-insulin dependent diabetes.

We have a further reservation concerning the stimulus given. We are not convinced that testing the hyperaemic response to heating assesses the hyperaemic response to injury. This is because this test does not distinguish between the neurogenic response to injury and the direct effect of the stimulus on the vessels. This has been investigated,[4] and diabetic patients with foot ulceration have been shown to have an impairment of the neurogenic response due to C fibre neuropathy but not of the direct response to injury. Possibly impairment of the neurogenic response is the important factor in the pathogenesis of such ulcers.

We do not think that the criteria suggested by Dr Sandeman and colleagues can eliminate the presence of macrovascular disease. Ankle brachial indices may be abnormally high because of incompressibility of arteries in diabetic patients due to sclerosis and calcification, which are common in diabetes, and without further investigations such as wave form analysis, oscillotonometry,[5] and arteriography macrovascular disease in this group cannot be excluded. The presence of foot pulses also does not necessarily denote a disease free proximal arterial tree, especially as diabetic patients seem to be spared atherosclerotic changes in the foot vessels.

Finally, we emphasise that foot ulceration in diabetic patients has a multifactorial pathogenesis. In addition to large vessel disease and microvascular impairment, abnormal areas of pressure on the feet, foot deformities, limited joint mobility, sensory neuropathy, minor trauma, and infections may play an important part in this debilitating condition.

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## Perinatal bereavement

SIR,—No one would disagree with the considerable advances that have been made by the profession in the management of perinatal death over the past 25 years described by Drs Stanford Bourne and Emanuel Lewis.[1] I would, however, like to draw attention to a major omission in their commentary—that of the role of the primary care team in this situation.

For most women who experience either a stillbirth or a miscarriage (spontaneous or therapeutic, for whatever reason), the greater part of their continued care will be provided by their general practitioner and their health visitor—particularly the health visitor if there are already children in the family. Obstetricians, paediatricians, midwives, and staff on special care baby units can to a large extent only provide care for "the immediate painful reactions." Although I would fully agree that the immediate reaction and behaviour of the attending hospital staff are of paramount importance, the ensuing support of those professionals who have responsibility for the continued care of the whole family needs to be acknowledged. General practitioners need full and immediate communication from their hospital colleagues as to the circumstances of the loss and some details of what has already been said to the parents. As time passes it is members of the primary care team, rather than the obstetric team, who need to be attuned to the "danger signals" of unresolved mourning.

To reinforce their role primary carers need to receive sufficient training in this area, for although tragedies such as perinatal death occur infrequently in any one practice, miscarriage is extremely common and general practitioners have been found to be lacking in their handling of parents at this time.[2] The mourning process should be carefully monitored and the use of booklets such as that produced by the Stillbirth and Neonatal Death Society (SANDS) is a useful adjunct for both parents and carers. Finally, of course, it is essential that prompt referral to an expert is available for those in whom the grieving goes wrong.

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SIR,—The recent editorial on perinatal bereavement highlights the improvements in the care of parents who experience late loss of pregnancy and mentions the value of counselling after termination for fetal abnormality in the middle of pregnancy.[1] Regrettably, the authors also make a series of statements about early loss of pregnancy that are unsubstantiated and cannot be allowed to pass unchallenged.

Although spontaneous miscarriage is about 10 times commoner than perinatal death, the psychological impact of early pregnancy loss has received scant attention in clinical practice and